

# Designation of Health Care Surrogate

Name \_\_\_\_\_

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility

Additional Instructions (optional): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name \_\_\_\_\_

Name \_\_\_\_\_

Signed: \_\_\_\_\_

Witnesses 1. \_\_\_\_\_

2. \_\_\_\_\_

*At least one witness must not be a husband or wife or a blood relative of the principal.*